44.71.2 The wages and fringes paid to workers engaged in formal Modified or Light-Duty Early-Return-To-Work Programs are allowable costs only to the extent that they cause a nursing facility to exceed its staffing pattern. Rehabilitation eligibility assessments are a cost to a limit of $300.00 per indemnity claimant. (Rehabilitation services provided to eligible injured workers are to be paid for by their employers insurer.)

44.8 Administrator in Training. The reasonable salary of an administrator in training will be accepted as an allowable cost for a period of six months provided there is a set policy, in writing, stating the training program to be followed, position to be filled, and provided that this individual obtain an administrator's license and serve as an administrator of a facility in the State of Maine. Prior approval in writing, from the Department, must be issued in advance of the date of any salary paid to an administrator in training. A request for prior approval must be received by the Department at least two (2) weeks prior to the desired effective start date of the administrator in training program. Failure to receive approval from the Department for the Administrator in Training salary will deem that salary an unallowable cost at time of audit. Failure to become an administrator within one year following completion of the examination to become a licensed administrator will result in the Department of Human Services recovering 100% of the amount allowed of the administrator in training. If the administrator in training discontinues the training program for any reason or fails to take the required examination to become a licensed administrator, 100% of the amount allowed will be recovered by the Department.

44.9 Acquisition Costs. Fifty percent of the acquisition cost of the rights to a nursing facility license shall be approved as a fixed cost in those situations where the purchaser acquires the entire existing nursing facility license of a provider and delicenses all or a significant portion (at least 50%) of the beds associated with that license. This amount will be amortized over a ten (10) year period, beginning with the subsequent fiscal year after completion of the acquisition. This acquisition cost will not include any fees (eg: accounting, legal) associated with the acquisition.

44.10 Occupancy Adjustment. To the extent that fixed costs are allowable, such cost will be adjusted for providers whose annual level of occupancy is less than ninety percent (90%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of ninety percent (90%). The 90% occupancy rate adjustment will be applied to fixed costs for facilities fiscal years beginning on or after 7/1/95, and shall be cost settled at the time of audit. For all new providers coming into the program, the 90% occupancy adjustment will not apply for the first 90 days of operation. It will, however, apply to the remaining months of their initial operating period. To the extent that fixed costs are allowable, such cost will be adjusted for providers with 60 or fewer beds whose annual level of occupancy is less than eighty-five percent (85%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of eighty-five percent (85%). The 85% occupancy rate adjustment will be applied to fixed costs for facilities fiscal years beginning on or after 7/1/97, and shall be cost settled at the time of audit. For all new providers of sixty (60) or fewer beds coming into the program, the 85% occupancy adjustment will not apply for the first 90 days of operation. It will, however, apply to the remaining months of their initial operating period.

44.11 Start Up Costs Applicability

Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof to the time the first resident is admitted for treatment, or where the start-up

costs apply only to nonrevenue-producing resident care functions or unallowable functions, to the time the areas are used for their intended purposes. Start-up costs are charged to operations. If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility will be accumulated in a single deferred charge account and will be amortized when the first resident is admitted for treatment. If a provider intends to prepare portions of its facility on a piecemeal basis (e.g., preparation of a floor or wing of a provider's facility is delayed), start-up costs would be capitalized and amortized separately for the portion(s) of the provider's facility prepared during different time periods. Moreover, if a provider expands its facility by constructing or purchasing additional buildings or wings, start-up costs should be capitalized and amortized separately for these areas.

Start-up costs that are incurred immediately before a provider enters the program and that are determined to be immaterial by the Department need not be capitalized, but rather will be charges to operations in the first cost reporting period. In the case where a provider incurs start-up costs while in the program and these costs are determined to be immaterial by the Department, these costs need not be capitalized, but will be charged to operations in the periods incurred.

For program reimbursement purposes, costs of the provider's facility and building equipment should be depreciated over the lives of these assets starting with the month the first resident is admitted for treatment, subject to the provider's method of determining depreciation in the year of acquisition or construction. Where portions of the provider's facility are prepared for resident care services after the initial start-up period, these asset costs applicable to each portion should be depreciated over the remaining lives of the applicable assets. If the portion of the facility is a resident care area, depreciation should start with the month the first resident is admitted for treatment. If the portion of the facility is a nonrevenue - producing resident care area or unallowable area, depreciation should begin when the area is opened for its intended purpose. Costs of major movable equipment, however, should be depreciated over the useful life or each item starting with the month the item is placed into operation.

Where a provider prepares all portions of its facility for resident care services at the same time and has capitalized start-up costs, the start-up costs must be amortized ratable over a period of 60 consecutive months beginning with the month in which the first resident is admitted for treatment.

Where a provider prorates portions of its facility for resident care services on a piecemeal basis, start-up costs must be capitalized and amortized separately for the portions of the provider's facility that are prepared for resident care services during different periods of time.

50 PUBLIC HEARING

The State of Maine will provide for public hearings as necessary in our State Plan, according to State procedures.

60 WAIVER

The failure of the Department to insist, in any one or more instances, upon the performance of any of the terms or conditions of these Principles, or to exercise any right under these principles, or to disapprove of any practice, accounting procedure, or item of account in any audit, shall not be construed as a waiver of future performance

of the right. The obligation of the Provider with respect to future performance shall continue, and the Department shall not be stopped from requiring such future performance.

70 SPECIAL SERVICE ALLOWANCE

70.1 Principle. A special ancillary service is to be distinguished from a service generally provided in the nursing facility.

70.1.1 A special ancillary service is that of an individual nature required in the case of a specific resident. This type of service is limited to professional services such as physical therapy, occupational therapy, and speech and hearing services. Special services of this nature must be billed monthly to the Department as separate items required for the care of individual recipients.

71 OMNIBUS RECONCILIATION ACT OF 1987 (OBRA 87)

OBRA 1987 has eliminated the distinction between ICFs and SNFs and the method of payment by such classifications. The statute provides for only one type of nursing facility. All nursing homes are now classified as a "nursing facility" with a single payment methodology.

80 ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE

80.1 Principle. For services provided on or after July 1, 2000, the Department will establish a prospective per diem rate to be paid to each facility until the end of its fiscal year. Each nursing facility's cost components for the fiscal year ending in 1998, as determined from the audited cost report (or as filed cost report) will be the basis for the base year computations (subject to upper limits). Allowable costs are separated into three components - direct, routine and fixed costs.

The base year direct and routine cost component costs will be trended forward using the inflationary factors from the table "HCFA Nursing Home Without Capital Market Basket" from the publication Health Care Costs published by DRI/McGraw-Hill as described in Section 91. (See Section 80.3 for a complete description of the rate setting process for the direct care component and inflation guidelines from the base year through 6/30/00.) Inflation factor data for salaries will be acquired from the Maine Health Care Facility Economic Trend Factor. The inflation factors will be based on the most recent DRI publications available at the times the rates are determined. Beginning October 1, 1993 the determination of the direct care cost component of each facility's base year rate will be computed by calculating the facility's case mix adjusted cost per day pursuant to Section 80.3. The prospective rate shall consist of three components : the direct care cost component as defined in Section 41, the routine cost component as defined in Section 43, and the fixed cost component as defined in Section 44.

80.2 FIXED COST COMPONENT

The fixed cost component shall be determined from the most recent audited or, if more recent information is approved by the Department, it shall be based on that more recent information using allowable costs as identified in Section 44. As described in Section 44, fixed costs will be adjusted for providers whose annual level of occupancy is less than ninety percent (90%). The adjustment to fixed costs shall be based upon a theoretical level of occupancy of ninety percent (90%). For all new providers coming into the program, the 90% occupancy adjustment will not apply for the first 90 days of operation. It will, however, apply to the remaining months of their initial operating periods. To the extent that fixed costs are allowable, such cost will be adjusted

for providers with 60 or fewer beds whose annual level of occupancy is less than eighty-five percent (85%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of eighty-five percent (85%). The 85% occupancy rate adjustment will be applied to fixed costs for facilities fiscal years beginning on or after 7/1/97, and shall be cost settled at the time of audit. For all new providers of sixty (60) or fewer beds coming into the program, the 85% occupancy adjustment will not apply for the first 30 days of operation. It will, however, apply to the remaining months of their initial operating period.

80.3 DIRECT CARE COST COMPONENT

80.3.1 Case Mix Reimbursement System

80.3.1.1 The direct care cost component utilizes a case mix reimbursement system. Case mix reimbursement takes into account the fact that some residents are more costly to care for than others. Thus the system requires:

(a) the assessment of residents on the Department's approved form - MDS as specified in Section 41.2.;

(b) the classification of residents into groups which are similar in resource utilization by use of the case mix resident classification groups as defined in Section 80.3.2.;

(c) a weighting system which quantifies the relative costliness of caring for different classes of residents by direct care staff to determine a facility's case mix index.

80.3.2 Case mix resident classification groups and weights

There are a total of 45 case mix resident classification groups, including one resident classification group used when residents can not be classified into one of the 44 clinical classification groups.

Each case mix classification group has a specific case mix weight as follows:

RESIDENT CLASSIFICATION GROUP	CASE MIX WEIGHT	
REHABILITATION		
REHAB ULTRA HI/ADL	16-18	1.986
REHAB ULTRA HI/ADL	9-15	1.426
REHAB ULTRA HI/ADL	4 - 8	1.165
REHAB VERY HI/ADL	16-18	1.756
REHAB VERY HI/ADL	9-15	1.562
REHAB VERY HI/ADL	4 - 8	1.217
REHAB HI/ADL	13-18	1.897
REHAB HI/ADL	8-12	1.559
REHAB HI/ADL	4 - 7	1.260
REHAB MED/ADL	15-18	2.051
REHAB MED/ADL	8 -15	1.635

REHAB MED/ADL	4 - 7	1.411
REHAB LOW/ADL	4 -18	1.829
REHAB LOW/ADL	4-11	1.256

EXTENSIVE

EXTENSIVE 3/ADL 7-18/Head Injury – ADL 15 - 18		2.484
EXTENSIVE 2/ADL 7-18/Head Injury – ADL 10 - 14		2.057
EXTENSIVE 1/ADL 7-18/Head Injury – ADL 7 - 9		1.910

SPECIAL CARE

SPECIAL CARE/ADL	17-18	1.841
SPECIAL CARE/ADL	15-16	1.709
SPECIAL CARE/ADL	7-14	1.511

CLINICALLY COMPLEX

CLIN. COMP W/DEP/ADL	17-18	1.826
CLIN. COMP/ADL	17-18	1.663
CLIN. COMP W/DEP/ADL	12-16	1.503
CLIN. COMP/ADL	12-16	1.389
CLIN. COMP W/DEP/ADL	4-11	1.331
CLIN. COMP/ADL	4-11	1.149

IMPAIRED COGNITION

COG. IMPAIR W/RN REHAB/ADL	6-10	1.199
COG. IMPAIR/ADL	6-10	1.152
COG. IMPAIR W/RN REHAB/ADL	4-5	0.945
COG. IMPAIR/ADL	4-5	0.888

BEHAVIOR PROBLEMS

BEHAVE PROB W/RN REHAB/ADL	6-10	1.180
BEHAVE PROB/ADL	6-10	1.123
BEHAVE PROB W/RN REHAB/ADL	4-5	0.905
BEHAVE PROB/ADL	4-5	0.759

PHYSICAL FUNCTIONS

PHYSICAL W/RN REHAB/ADL	16-18	1.454
PHYSICAL/ADL	16-18	1.421
PHYSICAL W/RN REHAB/ADL	11-15	1.323

PHYSICAL/ADL	11-15	1.281
PHYSICAL W/RN REHAB/ADL	9-10	1.219
PHYSICAL/ADL	9-10	1.088
PHYSICAL W/RN REHAB/ADL	6-8	0.833
PHYSICAL/ADL	6-8	0.854
PHYSICAL W/RN REHAB/ADL	4-5	0.776
PHYSICAL ADL	4-5	0.749
UNCLASSIFIED		0.749

80.3.3 Base Year Direct Care Cost Component

80.3.3.1 Source of base year cost data. The source for the direct care cost component of the base year cost data is the audited cost report (as filed cost report if an audit has not been completed) for the nursing facility's fiscal year ending in calendar year 1998, except for facilities whose Medicaid rates are determined in accordance with Sections 80.6 and 80.7. The total audited allowable direct care costs are divided by the total actual audited days. Recalculation of the upper limits shall not occur until subsequent rebasing of all components occurs.

80.3.3.2 Case Mix Index

The Bureau of Medical Services shall compute each facility's case mix index for the base year as follows:

(a) For non-hospital based facilities, the number of Medicaid residents in each case mix classification group shall be determined from the most recent MDS completed for all residents as of September 15, 1998 and received in the MDS CORE system by September 15, 2000. For hospital based facilities, the number of Medicaid residents in each case mix classification group shall be determined from the most recent MDS completed for all residents as of September 15, 1998 and received in the MDS CORE system by September 19, 2000. For new facilities, see 80.6.5.

(b) For each facility, the Bureau will multiply the number of Medicaid residents in each case mix classification group excluding the residents in the unclassified group by the case mix weight for the relevant classification group.

(c) The sum of these products divided by the total number of Medicaid residents excluding the residents in the unclassified group equals the facility's base year case mix index.

80.3.3.3 Base year case mix adjusted Medicaid cost per day.

Each facility's direct care case mix adjusted cost per day will be calculated as follows:

(a) The facility's direct care cost per day, as specified in Section 80.3.3.1, is divided by the facility's base year case mix index to yield the case mix adjusted cost per day.

80.3.3.4 Array of the base year case mix adjusted cost per day.

The direct care cost component will be inflated from the end of the facility's base year through June 30, 2000 using regional variations in labor costs calculated by using the average percentage increase in the weighted average actual salaries paid by nursing facilities to direct care staff as stated on the 1998 costs reports to the weighted average actual salaries paid to direct care staff as stated on the 1999 cost reports.

For each peer group (hospital based facilities, non-hospital based facilities with less than or equal to sixty beds, and non-hospital based facilities with greater than 60 beds), the Bureau shall array all nursing facilities case mix adjusted costs per day inflated to June 30, 2000 from high to low and identify the median.

80.3.3.5 Limits on the base year case mix adjusted cost per day.

For hospital based facilities, the upper limit on the base year case mix adjusted cost per day shall be the median plus fifty per cent (50%); for non-hospital based facilities with less than or equal to 60 beds, the upper limit on the base year case mix adjusted cost per day shall be the median plus ten per cent (10%); and for non-hospital based facilities with greater than 60 beds, the upper limit on the base year case mix adjusted cost per day shall be the median plus ten percent (10%).

80.3.3.6 Each facility's case mix direct care rate shall be the lesser of the limit in Section 80.3.3.5. or the facility's base year case mix adjusted cost per day.

80.3.4 Quarterly Calculation of the Direct Care Component

The Bureau of Medical Services shall compute the direct resident care cost component for each facility on a quarterly basis.

80.3.4.1 Calculation of the quarterly case mix index.

The Bureau of Medical Services shall compute each facility's quarterly case mix index for the rate period as follows:

For each facility the number of Medicaid residents in each case mix classification group shall be determined from the most recent MDS on all Medicaid residents in the facility as of the 15th day of the prior quarter (e.g. For a October 1 rate, the facility's case mix index would be computed using the most recent assessments of Medicaid residents with an assessment date of June 15.)

For each facility, the Bureau will multiply the number of Medicaid residents in each case mix classification group including those in the unclassified group by the case mix weight for the relevant classification group. The sum of these products divided by the total number of Medicaid residents equals the facility's quarterly case mix index. The roster sent to the nursing facility for confirmation of residents in the nursing facility is relied upon by the Department in determining the residents in the nursing facility. It is the nursing facilities responsibility to check the roster and make corrections within one week of receiving the roster and submit

such corrections to the Department or it's designee. MDS Corrections tor assessments used in the calculation of a facility's quarterly case mix index will not be considered in the calculation of the index when received in the MDS CORE system after the calculation of the rate by the Bureau of Medical Services.

For purposes of this section, resident assessments that are incomplete due to the death, discharge, or hospital admission of the resident during the time frame in which the assessment must be completed will not be included in the unclassified group or used to compute the case mix index. (Note: For Medicaid residents, the facility would be paid the facility rate for the number of days the resident is at the facility.)

80.3.4.2 Direct care rate per day

The direct care rate per day shall be computed by multiplying the allowable base year case mix adjusted cost per day by the applicable case mix index.

80.3.4.3 The direct cost, as defined in Section 41, shall be determined by adjusting the allowable necessary and reasonable direct care costs (subject to the limitations cited in Section 41) from the base year by the inflationary factor defined in Section 91, for dates of service on or after July 1, 2000.

80.3.4.4 Public Law 99, Chapter 731, appropriated funds to assist nursing facilities to maintain minimum staffing ratios. The Department used base year cost report information (in aggregate) in determining whether a facility was at or below the minimum staffing requirements. The Department excluded two full-time equivalent direct care positions for every 50 licensed beds from the direct care hours to allow for staff time that may not involve hands-on direct care when calculating whether a facility was meeting the minimum staffing requirements. For purposes of determining the total base year allowable direct care cost, nursing facilities not meeting the minimum staffing ratios will have their base year allowable direct care cost component increased by the weighted average hourly rate of their base year direct care staff costs plus the statewide average fringe benefits percentage times the number of hours needed to meet those minimum staffing ratios.

The minimum staffing ratios are:

(a) 1 direct care staff person on the day shift to every 5 residents.
(b) 1 direct care staff person on the evening shift to every 10 residents.
(c) 1 direct care staff person on the night shift for every 15 residents.

80.3.4.4.1 The law defines direct care staff, for the purposes of meeting these minimum requirements as registered nurses, licensed practical nurses, and certified nursing assistants who provide direct care to nursing facility residents.

80.3.4.4.2 Direct Care is defined as hands-on care provided to residents, including, but not limited to, feeding, bathing, toileting, dressing, lifting, and moving residents. Direct care does not include food preparation, housekeeping, or laundry services except in circumstances when such services are required to meet the needs of an individual resident on a given occasion.

80.3.5 Direct Care Cost Settlement.

For dates of service beginning on or after July 1, 2000 facilities that incur allowable direct care costs during their fiscal year which are less than their prospective rate for direct care will receive their actual cost. .

Facilities, which incur allowable direct care costs during their fiscal year in excess of their prospective rate for direct care, will receive no more than the amount allowed by the prospective rate.

80.5 ROUTINE COST COMPONENT

Routine Cost component base year rates shall be computed as follows:

80.5.1 Using each facility's base year fiscal year ending in calendar year 1998) audited cost report, the provider's base year total allowable routine costs shall be determined in accordance with Section 43.

80.5.2 The base year per diem allowable routine care costs for each facility shall be calculated by dividing the base year total allowable routine care costs by the greater of actual or 85% of the total Base Year resident days for hospital based facilities and non-hospital based facilities with less than or equal to 60 beds. The base year per diem allowable routine care costs for non-hospital based facilities with greater than 60 beds shall be calculated by dividing the base year total allowable routine care costs by the greater of actual or 90% of the total Base Year resident days.

80.5.3 The Bureau of Medical Services will array all nursing facility's base year per diem allowable routine costs adjusted to a common fiscal year by the appropriate inflationary factor, from low to high and identify the median.

80.5.4 For hospital based facilities, the upper limit on the base year cost per day shall be the median plus fifteen per cent (15%); for non-hospital based facilities with less than or equal to 60 beds, the upper limit on the base year case mix adjusted cost per day shall be the median plus ten per cent (10%); and for non-hospital based facilities with greater than 60 beds, the upper limit on the base year cost per day shall be the median plus seven percent (7%). The per diem upper limits shall be services beginning on or after July 1, 2000.

80.5.5 Each facility's Base Year Routine Care cost per diem rate shall be the lesser of the limit set in Subsection 80.5.4 or the facility's base year per diem allowable routine care costs.

80.5.6 Routine Cost Settlement. For dates of service beginning on or after July 1, 2000 routine cost savings will result in the facility returning this savings to the Department at time of audit. Facilities that incur allowable routine costs less than their prospective rate for routine costs will receive their actual allowable costs. Facilities that incur allowable routine costs during their fiscal year in excess of the routine cost component of the prospective rate will receive no more than the amount allowed by the prospective rate.

80.6 RATES FOR FACILITIES RECENTLY SOLD, RENOVATED OR NEW FACILITIES

80.6.1 A nursing home project that proposes renovation, replacement or other actions that will increase Medicaid costs and for which an application is filed after March 1, 1993 may be approved only if appropriations have been made by the Legislature expressly for the purpose of meeting those costs. The basis for establishing the facility's rate through the certificate of need review is the lesser of the rate supported by the costs submitted by the applicant or the statewide base year median for the direct and routine cost components inflated to the current period. The fixed costs determined through the Certificate of Need review process must be approved by the Bureau of Medical Services (also see Section 44.25.2).

80.6.1.1 For a facility sold after October 1, 1993, the direct and routine rate shall be the lessor of the rate of the seller or the rate supported by the costs submitted by the purchaser of the facility. The fixed cost component recognized by the Medicaid program will be determined through the Certificate of Need review process. Fixed costs determined through the certificate of need review process must be approved by the Bureau of Medical Services.

80.6.2 Nursing facility's not required to file a certificate of need application, currently participating in the Medicaid program, that undergo replacement and/or renovation will have their appropriate cost components adjusted to reflect any change in allocated costs. However, the rates established for the affected cost components will not exceed the state median rates for facility's in its peer group. In those instances that the data supplied by the nursing facility to the Department indicates that any one component rate should be less than the current rate the Department will assign the lower rate for that component to the nursing facility.

80.6.3 The reimbursement rates set, as stated in Sections 80.6.1 and 80.6.2, will remain in effect for the period of three (3) years from the date that they are set under these Principles.

80.6.4 At the conclusion of the three years, the reimbursement rate will be rebased to the fiscal year stated in Sections 41.3.1 and 43 or the most recent audited fiscal year occurring after the opening of the new facility, the completion of the new renovation, or the sale of the facility, whichever is the most current.

80.6.5 For the first, second, and third rate setting period, the base year case mix index that will be used for the prospective rate calculation will be 1.000. Similarly, the quarterly case mix index will be set at 1.000. For the fourth rate setting period, the base year index will be calculated based on all the nursing facility's Medicaid resident's average case mix indexes excluding the not classified group as of the 15th of the fourth month after the fiscal year begin date of the pro forma cost report. For example, if a facility's fiscal year beginning was January 1, 2001, the base year index would be calculated using all Medicaid residents with classifiable assessments as of April 15, 2001. The quarterly rate setting index would then be set as specified in Section 80.3.4.

80.7 NURSING HOME CONVERSIONS

80.71 In reference to Public Law 1981, c. 705, Pt. V, § 304, the following guidelines have been established in relation to how nursing facilities that convert nursing facility beds to residential care beds will be reimbursed:

80.71.1 A proforma step down cost report for the year in which the bed conversion will take place or the first full fiscal year in which the facility will operate with both nursing facility and residential care facility levels of care will be submitted to the Bureau of Elder and Adult Services and to the Division of Reimbursement and Financial Services of the Bureau of Medical Services.

80.71.2 Based on an analysis of the cost report by the Department, the allowable costs will be determined based on the Principles of Reimbursement for Nursing Facilities contained herein.

80.71.3 The occupancy level that will be used in the calculation of the rate will be set at the days included on the pro forma cost report submitted at the time of the conversion or at the 95% occupancy level, whichever is greater.

80.71.4 The case mix index will be determined as stated in Sections 41.2 , 80.3.1, 80.3.2, 80.3.3.2, and 80.3.4.1.

80.71.5 The upper limits for the direct and routine care cost components will be inflated forward to the end of the fiscal year of the proforma cost report submitted as required in Section 80.71.1.

80.71.6 The reimbursement rates set, as stated in Sections 80.71.1 and 80.71.5, will remain in effect for the period of three (3) years from the date that they are set under these Principles. The direct and routine components will be inflated to the current year, subject to the peer group cap. Reimbursement rates and all rate letters will have an effective date of the first day of the subsequent month after the date of the licensure change.

80.71.7 At the conclusion of the three years, the reimbursement rate will be rebased to the fiscal year stated in Sections 41.3.1, 42.1, and 43 or the most recent audited full fiscal year occurring after the conversion of nursing facility beds to residential care beds, whichever is the most current.

80.71.8 Section 80.7 is effective for Nursing Facilities with the effective date of conversion of nursing facility beds to residential care facility beds occurring on or after January 1, 1996.

81 INTERIM AND SUBSEQUENT RATES

81.1 Interim Rate and Subsequent Year Rates. Fifteen days prior to the beginning of the facility's fiscal year, an interim rate will be established by using the fixed cost component of the previous fiscal year and adding to it the inflated routine cost components of the base year. The interim rate in subsequent fiscal years will be determined in the same manner as outlined above. The direct cost component is computed as specified in Section 80.3.4.

82 FINAL PROSPECTIVE RATE.

Upon final audit of all nursing facility's base year cost reports, the Department will determine a final prospective rate.

82.1 A cost report is settled if there is no request for reconsideration of the Division of Audits findings made within the required time frame or, if such request for reconsideration was made and the Division of Audit has issued a final revised audit report.

84 FINAL AUDIT OF FIRST AND SUBSEQUENT PROSPECTIVE YEARS.

84.1 Principle. All facilities will be required to submit a cost report in accordance with Section 32 at the end of their fiscal year on cost report forms approved by the Department. The Department will conduct a final audit of each facility's cost report, which may consist of a full scope examination by Department personnel and which will be conducted on an annual basis.

84.2 Upon final audit of a facility's cost report for the first and subsequent prospective years, the Department will:

84.2.1 determine the actual allowable fixed costs incurred by the facility during the cost reporting period,

84.2.2 determine the occupancy levels of the nursing facility,

84.2.3 determine reimbursable direct care costs incurred by the facility during the reporting period per Section 80.3.5.

84.2.4 Determine the actual allowable routine costs incurred by the facility during the cost reporting period per Section 80.5.6.

84.2.5 Calculate a final rate.

84.2.6 Determine final settlement by calculating the difference between the audited final rate and the interim rate(s) paid to the provider times the Medicaid utilization.

Nursing facilities that transfer a cost center from one cost component to another cost component resulting in increased Medicaid costs will have the affected cost components adjusted at time of audit.

Upon final audit of a facility's cost report, the Department will calculate a final prospective rate and determine the lump sum settlement amounts either due to or from the nursing facility.

The Division of Audit final audit adjustment to the nursing facilities annual cost report will consider the impact of days waiting placement as specified in the Principles of Reimbursement for Residential Care Facilities. Fixed cost reimbursement for the nursing facility will not be affected by days waiting placement reimbursement to the nursing facilities.

85 SETTLEMENT OF FIXED EXPENSES

85.1 The Department will reimburse facilities for the actual allowable fixed costs which are incurred during a fiscal year. Upon final audit of a facility's cost report, if the Department's share of the allowable fixed costs actually incurred by the facility is greater than the amount paid by the Department (the fixed cost component of

the final prospective rate multiplied by the number of days of care provided to Medicaid beneficiaries), the difference will be paid to the facility by the Department. If, the Department's appropriate share of the allowable fixed costs actually incurred by a facility is less than the amount paid by the Department, the difference will be paid to the Department by the facility.

85.2 Federal regulations state that during the first year of implementing the nursing home reform requirements, the new costs which a facility must incur to comply with these requirements will be treated as a fixed cost. The facility must maintain the appropriate documentation in order for these costs to be identified at the time of the facility's final audit.

The cost associated with meeting the Nursing Home Reform Act of 1987 requirements will continue to be treated as a fixed cost through the facility's first full fiscal year after September 30, 1991 and will not be included in the determination of incentive payments which the facility might be entitled to receive as a result of its performance during that year. Thereafter, the cost associated with implementing the Nursing Home Reform Act of 1987 will be considered in the appropriate cost component and will be added to the facility's final prospective rate.

Upon final audit of a facility's cost report, if the Department's share of the allowable OBRA costs actually incurred by the facility is greater than the amount paid by the Department, the Department will pay the facility the difference. If on the other hand, the Department's appropriate share of the allowable OBRA costs actually incurred by a facility is less than the amount paid by the Department, the difference will be paid to the Department by the facility.

86 ESTABLISHMENT OF PEER GROUP

86.1 Establishment of Peer Group. All Nursing care facilities will be included in one of three peer groups. Hospital based nursing facilities (excluding governmental institutions) will comprise one peer group, non-hospital based facilities with sixty or fewer beds with compose a second peer group, and non-hospital based facilities with more than sixty beds will compose the third peer group. Please refer to Appendix C for a description of a hospital based nursing facility. For determining the Medicare upper limit, it should be noted that the establishment of these three peer groups in developing a payment model is not an accepted model in determining the upper limits as established by Federal Statute. The Federal Statute recognizes free standing nursing facilities in determining the upper limit. The upper limit for hospital based facilities is based on one-half the routine costs of freestanding facilities and one-half the costs of hospital based facilities. Therefore, the appropriate Medicare upper limit test will be applied to all nursing facilities.

88 CALCULATION OF OVERPAYMENTS OR UNDERPAYMENTS.

Upon determination of the final rate as outlined in section 84 above, the Department will calculate the net amount of any overpayments or underpayments made to the facility.

If the Department determines that it has underpaid a facility, the Department will estimate the amount due and forward the result to the facility within thirty days. If the Department determines that it has overpaid a facility, the Department will so notify the facility. Facilities will pay the total overpayment within sixty (60) days of the notice of overpayment or request the Department to reduce facility payments during the balance of its fiscal year

by the amount of the overpayment. Facilities that do not notify the Department of the method by which they intend to repay the overpayment will, beginning 60 days after their receipt of the notice of overpayment, have their subsequent payments from the Department reduced by the amount of overpayment.

If a facility appeals a determination of overpayment, the facility must repay within sixty (60) days of the notice of overpayment all portions of the determined overpayment except those that are expressly disputed and for which specific dollar values are identified. Repayment of each such specifically disputed portion and identified amount shall be stayed pending resolution of the dispute with respect thereto. The amount of money in dispute must be identified in the manner outlined in Section 150.

The net amount of any over or underpayment made to the facility will be based on 1) the calculation of actual fixed expenses incurred in the prior year and 2) the estimated difference in amount due or paid based on the interim versus final prospective rate.

89 BEDBANKING OF NURSING FACILITY BEDS

89.1 Any bedbanking request must be submitted to the Department for review by the Bureau of Elder and Adult Services and the Bureau of Medical Services. Nursing facilities are permitted to bank nursing facility beds, according to the guidelines contained in Title 22, Section 304, providing the space left vacant in the facility is not used for the creation of private rooms. In addition to those guidelines, a floor plan must be submitted to the Bureau of Elder and Adult Services which describes the intended use of the banked bed spaces. This floor plan will be reviewed by the Department. Reimbursement of costs associated with the banked beds will be allowed to the extent that such costs have been approved by the Department. Reasons that the Department may deny the space as reimbursable under these Principles includes, but is not limited to, the following:

89.11 the use of the space is not reimbursable under the criteria contained in these Principles,

89.12 the proposed purpose of the use of the space has already been designated by other space within the facility and this would constitute duplication of use,

89.13 the proposed use of the space is not deemed to be in the best interest of the physical, emotional, and safety needs of the residents (In this case, a recommendation by the Department may be made for an alternative use of the space).

89.2 Pursuant to Title 22, Section 304, the following cost components shall be decreased by a percentage equal to the percentage of bed days decreased by the banking of the beds. Total bed days used to calculate this percentage will be the audited days (as filed if audited days are not available) from the base year cost report. (e.g. If a facility decreased the number of beds by 25%, and the total bed days in the base year equals 40000 and the facility was at 90% occupancy = 36000 days, then the bed days used in the calculation of the rate after the bedbanking would equal 90% of 30000 days or 27000 days.) This percentage decrease would be used in the calculation of the new rate for the following cost components based on what the total audited costs (as filed, if audited costs are not available) in the base year: